FIREWORKS INJURY REPORTING

INDIANA STATE DEPARTMENT OF HEALTH

State Form 51497 (10-03)

INSTRUCTIONS: 1. Print information to ensure legibility.
2. Fill in circles for appropriate choice.
3. Complete all items on the forms.
4. Per HEA 1131, report must be completed within 5 business days after examination of the injury.

Section 1: Demographic Information on Injured Person

Date of Medical Evaluation: _____

Last Name: _____First Name: _____ MI: _____

Phone Number: (____) _____ - _____ Date of birth: _____ Age: _____

If child, name of parent or guardian (Last, First, MI): _____

Street Address: _____

City / Town: _____ **State:** _____ **Zip:** _____ **County:** _____

Sex:	**Race (choose all that apply)**	**Ethnicity**
o Male o Female o Unknown	o White o Black or African American o Asian o Native Hawaiian or Other Pacific Islander o American Indian or Alaska Native o Unknown	o Hispanic or Latino o Not Hispanic or Latino

Section 2—Site of Report: Hospital / Emergency Department / Physician Office / Surgical Center

o **Hospital Name:** _____
o **Hospital / Related Site:** o **Emergency Department** o **Urgent Care Center**
o **Ambulatory Surgical Center (Name):** _____
o **If reporting from a Health Care Provider Office, State Name of Practice:**
_____

Physician Name: _____

Contact through: o **Email:** _____ o **Office:** (____) _____ - _____

Street Address: _____

City / Town: _____ **State:** _____ **Zip:** _____ **County:** _____

(Person Reporting) Title: _____

Last Name: _____ First Name: _____

Phone Number: (____) _____ - _____ Email: _____

Name of Injured Person: _____

Section 3: Injury and Surrounding Circumstances	
Body Part Involved (note all involved)	**Type of Injury (note all involved)**
o Hand(s) / Finger o Arm o Eye(s) o Face / Ears / Head o Leg(s) o Trunk o Other _____	o Burn o 1st Degree o 2nd Degree o 3rd Degree o Contusion / Laceration / Abrasion o Puncture Wound o Penetrating Foreign Body / Missile o Sprain / Fracture o Other _____
Outcome (note all that apply)	**Circumstances of Injury**
o Death o Evaluated in Emergency Department o Released to home o Admitted to hospital o Transferred to _____ o Evaluated in provider office o Released to home o Admitted to hospital o Other (specify) **If hospitalized:** Date of admission:_____ Date of discharge: _____ (if available)	Date of injury: _____ Time of injury:_____ o AM o PM Locale of injury: o **Private** home / yard / property o Friend / neighbor / relative home / yard / property o **Public** park / street / property o School property o Other (specify)_____ **If eye injury:** o no eye protection o eyeglasses or safety glasses o contact lenses
Risk Factors at the time of injury	**Type of Fireworks / Pyrotechnics**
o Alcohol Consumption o By injured person o Within 3 hours of injury o Blood alcohol tested o Unknown o By other people at the scene o If injured person is less than 18 years of age, was an adult present? o Yes o No o Unknown o Injured person was a bystander	o Firecrackers o Rockets (i.e., bottle rockets) o Sparklers o Twisters / "Jumping Jacks" o Lighting gunpowder o Homemade, altered device o Aerial devices o Other (fountains, roman candles, etc.) o Pyrotechnics – state Event or Location involved _____ o Unspecified / Unknown
Mechanism / Problem (if known)	**Comments / Additional Information**
o Malfunction / timing of firework o Errant path of rocket o Debris from aerial fireworks o Mishandling (relighting, throwing, etc.) o Other o Unknown	

Please fax this form to (317) 233-7805: Attn: Injury Epidemiologist----phone (317) 234-2890
Or mail to: Indiana State Dept of Health
2 North Meridian Street, 6A
Indianapolis, IN 46204